Annual Equality Report 2016-17

Introduction

1. NICE's role is to improve outcomes for people using the NHS and other public health and social care services. We do this by:

    - Producing evidence based guidance and advice for health, public health and social care practitioners.
    - Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services.
    - Providing a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care.

2. NICE is committed to eliminating discrimination, harassment and victimisation, advancing equality of opportunity, and fostering good relations between people who share the protected characteristics defined in the Equality Act 2010 of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation, and those who do not. We aim to comply with the Human Rights Act 1998 and are concerned with tackling health inequalities associated with underlying socioeconomic factors and inequities in access to healthcare and opportunities to improve health for certain disadvantaged groups.

3. This report covers our responsibility under Equality Act Regulations to publish information annually to demonstrate our compliance with the public sector equality duty. It consists of five main sections:

    - **Summary** of key data relating to composition of advisory committees, equality analysis in guidance production and composition of the workforce
    - **NICE's equality aims** and our formal objectives as part of the public sector equality duty
    - **Composition of, and appointments to, NICE committees:** information about the effects of our policy on recruiting members to our advisory bodies
    - **Equality issues impacting on NICE guidance:** the effects of equality analysis on NICE's guidance recommendations
    - **Workforce:** summary of the workforce profile by equality category. More detail about the workforce can be found in the annual workforce report.

4. The report covers guidance produced and appointments to the committees in the period 1 April 2016 to 31 March 2017, and the workforce profile at 31 March 2017. The survey of committee members was undertaken in May and June 2017, covering those who were a member of a committee at 31 March 2017.

Summary

NICE's equality objectives

5. Actions to deliver the 2016 to 2020 equality objectives are underway, coordinated by NICE's cross-Institute equality and diversity group. We will also submit data on our performance against the Workforce Race Equality Standard (WRES) indicators to NHS England. This will enable benchmarking against the NHS and other health Arms' Length Bodies.

Composition of and appointments to NICE committees

6. The survey of advisory body members reported that:

    - 50% of respondents were women and 48% were men. 2% indicated that it was their choice not to answer the question or gave no response. In last year's survey 46% of respondents were women and 43% were men.
    - 11% identified themselves as disabled (8% in last year's survey)
    - 76% identified themselves as of white British ethnicity (78% in last year's survey)
    - 49% were between 51 and 65 years old, with 86% between 36 and 65 years old (the equivalent figures in last year's survey were 49% and 88% respectively)
    - 86% identified themselves as heterosexual (88% in last year's survey)
    - 44% identified themselves as of Christian belief, with 39% declaring they had no religion or belief (the equivalent figures in last year's survey were 47% and 37% respectively).

7. Monitoring information collected during the process to appoint members to the advisory bodies in 2016-17 indicates that:

    - Across the roles overall, broadly similar proportions of people sharing the various protected characteristics were appointed to advisory bodies as applied.
    - The profile of applicants and appointees in terms of protected characteristics varies between lay and non-lay roles. This is likely due to the different skills and experience sought for lay and non-lay roles.

Guidance production

8. Equality considerations continue to be taken into account in the development of NICE guidance. In 2016-17:

    - There was a decrease in the number of equality issues identified and also those which subsequently impacted on recommendations compared to 2015-16, both in absolute terms and in proportion to the number of guidance publications.
    - Age, disability and race continue to account for the greatest number of equality issues both in terms of initial identification and those which impacted on recommendations.

9. The variation in the identification of equality considerations will be explored further, specifically whether this is due to differences between the guidance programmes or inconsistency in applying the equality impact assessment process.

Workforce

10. Just over half (56%) of NICE staff are 40 years old or less, and two thirds (67%) are women. 79% of staff identify themselves as of white ethnicity and 3% of the workforce identified themselves as disabled.

NICE's equality objectives

11. In line with our obligations under the public sector equality duty, NICE sets equality objectives. In 2016 the Board agreed the following equality objectives covering the period 2016 to 2020:

    - **Objective 1:** To increase the proportion of advisory body position applications that are from individuals who describe themselves as from black, Asian and minority ethnic groups.
    - **Objective 2:** To increase the proportion of staff from black, Asian and minority ethnic groups in senior roles (agenda for change band 7 and above) across the organisation.

Equality objective 1

Rationale

12. NICE guidance is developed by independent advisory bodies made up of health, social care and public health professionals and practitioners; people using services, their unpaid carers and other lay people; academics; health and social

care commissioners; local authority elected members; and other experts on the topics covered by guidance including from the life sciences industry.

13. We seek diverse membership so that advisory bodies are representative of the population and provide a wide range of viewpoints and experiences to inform guidance and improve its quality. This helps us meet our equality duty to have 'due regard' to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people when carrying out our activities.

14. The information in the 2014-15 annual equality report indicated that broadly similar proportions of people sharing protected characteristics were appointed to the advisory bodies as applied. However, the report indicated that compared to the overall population, there was underrepresentation of people who describe themselves as from black and Asian ethnic groups.

15. NICE cannot positively discriminate in favour of applicants based on ethnicity or other protected characteristic, but it is acceptable to encourage a diverse range of applicants. Therefore the Board agreed an objective to increase the diversity of applicants to our advisory bodies. Specifically, we are seeking year on year increases in the proportion of the advisory body position applications that are from individuals who describe themselves as from black, Asian and minority ethnic groups.

Progress to date and further planned actions

16. An action plan is in place for this multi-year objective. The initial priority in this first year has been to gather feedback on the barriers to involvement with NICE's advisory committees, experience of applying to and working with our committees, and actions we could take to increase applications from individuals from black, Asian and minority ethnic communities.

17. We amended this year's survey of committee members[1] that informs the equality report to include questions on the committee recruitment process. Committee members were asked to provide feedback on the recruitment paperwork, and their experience of the interview, application process, and being on a committee. The proportion of committee members that stated their experience of the interview and their overall experience of the recruitment process was 'excellent' was higher for respondents who identified themselves as of non-white ethnicity[2] than for those who identified themselves of white ethnicity. We also asked for suggestions on what support during the application process would encourage applications from black, Asian and minority ethnic communities. We received a number of suggestions covering matters such as the way we advertise roles,

[1] The Picker survey that is discussed later in the report

[2] Asian or Asian British; Black or Black British; Mixed; Other Ethnic Group

build links with representative groups/bodies, and promote NICE's work and commitment to diversity. We are using these to inform our action plan.

18. We have amended the letter sent to applicants to our committees who are not appointed to include a link to a confidential web-based survey that seeks feedback on the recruitment process and asks for suggestions on how this could be improved. Respondents are invited to indicate their ethnic group, which will help us identify actions that could be particularly helpful in respect of our equality objective.

19. The Public Involvement Programme (PIP) is currently undertaking a programme of meetings with key organisations to identify the barriers to involvement for potential lay member applicants. These meetings are being used to gather intelligence on the best ways to involve people using services from black, Asian and minority ethnic communities. In addition, PIP is arranging a programme of three regional workshops to take place across England (the North, Midlands and the South) from September 2017, which will review the current lay member recruitment information, process and current communication channels with people from black, Asian and minority ethnic communities to co-design a way of applying for a NICE lay member vacancy that will work for them.

20. We are using the feedback received from the committee member survey to update our communications to encourage people from black, Asian and minority ethnic communities to apply for committee posts. This will include uploading interviews with current committee members about their experience, reviewing use of social media and regional media to publicise committee vacancies and engage with communities, and updating the committee recruitment pages on the website to make the content as straightforward as possible. The PIP activities will also inform this work.

21. In order to promote our non-lay positions, we are seeking to engage with groups that represent health and social care professionals from black, Asian and minority ethnic groups, and also with equality and diversity leads in NHS organisations.

22. The ethnicity of applicants, and those appointed, to NICE's advisory committees in 2015-16 and 2016-17 is outlined below.

Table 1: Ethnicity of applicants to NICE committees

Ethnicity	% of all applicants	
	2015-16	2016-17
Asian or Asian British	8%	9%
Black or Black British	2%	2%
Mixed	2%	3%
White British	67%	67%
Other white background	9%	8%
Any other ethnic group	2%	2%
Undisclosed	4%	4%
Data not held	6%	5%

23. Whilst the actions in this first year have focused on gathering feedback to inform the multi-year action plan, there has been a year on year increase in the proportion of applicants for advisory committee roles who described themselves as of Asian/Asian British and mixed ethnicity. We would hope to see further increases next year as the actions outlined above progress.

Equality objective 2

Rationale

24. Our second objective recognises the centrality of our staff to the successful delivery of our functions. A diverse workforce supports the delivery of the general equality duty and enables us to draw upon the widest pool of talent.

25. The diversity of our workforce in our management roles does not fully reflect the diversity of the wider population. The majority of staff at NICE from black, Asian and minority ethnic groups occupy junior roles (agenda for change bands 4 and 5) and we traditionally have not had a clear strategy for recruiting and developing talent into more senior roles.

26. The Board therefore agreed a specific objective focused on increasing the number of staff from black, Asian and minority ethnic groups in management roles through targeted development programmes and resourcing strategies. We are seeking year on year increases in the proportion of staff from black, Asian and minority ethnic groups in senior roles (agenda for change band 7 and above) across the organisation.

Progress to date and further planned actions

27. We have increased our vacancy advertising reach by posting all jobs to Indeed and Total Jobs (two of the UK's leading jobs boards). Additionally, all roles at Band 7 and above are now advertised on LinkedIn. Some senior roles have been advertised on national specialist jobs boards including The Guardian and People Management. This additional advertising ensures we are reaching a wider candidate pool than advertising through NHS Jobs alone.

28. The number of black, Asian and minority ethnic staff in senior roles (band 7 and above) has increased by 7% since last year – from 55 staff at 31 March 2016 to 59 staff at 31 March 2017. This increased the proportion of staff in band 7 and above from black, Asian and minority ethnic groups from 11% to 13%.

29. NICE is committed to continuing to promote opportunities to potential candidates and existing staff. We are building relationships with other organisations with a view to sharing development opportunities such as vacancies, secondments, training and forums. This will strengthen further the support we are able to offer our staff.

NICE equality and diversity group (NEDG)

30. The NICE equality and diversity group supports NICE to deliver its obligations under the Equality Act in relation to guidance production. The group meets quarterly and includes members from each centre/directorate, plus the Public Involvement Programme and Corporate Office. It is chaired by a Programme Director from the Centre for Guidelines.

31. In addition to overseeing the delivery of our equality objectives and coordinating input to the annual equality report, the group seeks to share good practice across NICE and provide a forum for discussing and proposing solutions to cross-Institute equality issues.

32. This year the group discussed actions to deliver the equality objectives, the questions for the annual survey of committee members, and equality and diversity issues facing NICE teams. The group considered terminology to use in NICE guidance, including in respect of learning disabilities, and gender reassignment. It is also looking at the provision of accessible information for the public when browsing guidance on the NICE website.

33. The group now includes a member of NICE's field team to help the team promote opportunities on NICE committees when engaging with health and social care partners, as part of the action plan for equality objective 1.

Workforce Race Equality Standard (WRES)

34. Under the Workforce Race Equality Standard (WRES) all organisations with NHS contracts are required to demonstrate progress against a number of indicators of race equality. NICE will join a number of national health Arms' Length Bodies (ALBs) in submitting this data to NHS England, which will enable us to benchmark performance against the ALBs and NHS.

35. We have also sought advice from the Director of the WRES Implementation Team at NHS England on actions to deliver our equality objectives, including organisations representing health and social care professionals from black, Asian and ethnic minority groups.

Composition of and appointments to NICE committees

36. As noted above, diversity in advisory body membership contributes to the aims of NICE's equality programme and improves the quality of guidance. It also supports the public sector equality duty of fostering good relations between those sharing protected characteristics and those who do not.

37. We collect information on the background of those applying for positions on our advisory bodies. We compare this to the background of those subsequently appointed to positions. This enables us to monitor the impact of our recruitment processes.

Equalities monitoring of 2016-17 applications and appointments

38. Across the roles overall, broadly similar proportions of people sharing the various protected characteristics were appointed to advisory bodies as applied. Further information, by protected characteristic, is outlined below.

Gender

39. The proportion of applicants and appointees who were women was higher for lay roles than non-lay roles. 57% of lay applicants and 61% of lay appointees were women. 43% of the non-lay applicants and 42% of the non-lay appointees were women.

Disability

40. The proportion of applicants and appointees who identified themselves as disabled was higher for lay roles than non-lay roles. 28% of all lay applicants and 34% of lay appointees identified themselves as disabled. This compares to 2% for non-lay applicants and appointees.

Ethnicity

41. White British was the most frequently declared ethnicity for applicants and appointees, accounting for the following proportion of applicants and appointees:

    - Lay applicants: 71%
    - Lay appointees: 78%
    - Non-lay applicants: 66%
    - Non-lay appointees: 70%.

Age

42. The majority of applicants and appointees were between 36 and 65 years old:

    - Lay applicants: 64%
    - Lay appointees: 66%
    - Non-lay applicants: 80%
    - Non-lay appointees: 84%.

43. As in 2015-16, the proportion of applicants and appointees between 18 and 35 years old and over 65 years old is higher for lay role than for non-lay roles.

Sexual orientation

44. The majority of applicants and appointees identified themselves as heterosexual for both lay and non-lay roles:

    - Lay applicants: 81%
    - Lay appointees: 82%
    - Non-lay applicants: 82%
    - Non-lay appointees: 83%.

Religion or belief

45. Those identifying themselves as of Christian belief represented the largest group of applicants and appointees for both lay and non-lay roles:

    - Lay applicants: 43%
    - Lay appointees: 45%
    - Non-lay applicants: 42%
    - Non-lay appointees: 44%.

46. The proportion of applicants and appointees who stated that they did not have a religion increased from 14% and 12% in 2015-16 to 20% and 19% in 2016-17.

Data quality

47. It is not compulsory to provide equalities monitoring information when applying for a committee role. Prior to 2016 one of NICE's formal equality objectives sought to more clearly explain to prospective employees and members of advisory bodies why we collect data on the protected characteristics under equality legislation, to better inform their decisions on whether or not to declare this information in our monitoring forms. We also sought to strengthen internal processes to collate and manage the data provided by applicants to our committees to address gaps in the data.

48. It is therefore positive that the data quality has continued to improve with monitoring forms returned for 95% of applicants and 97% of all appointees in 2016-17, up from 94% and 93% in 2015-16 respectively. At least 96% of applicants and appointees in 2016-17 who returned the monitoring forms disclosed their age, gender, ethnic origin, and whether they had a disability.

The Picker survey of current committee members

49. As in previous years, we commissioned Picker to carry out a web based survey to provide a snapshot of the makeup of the NICE committees. This provides us with a view of the current composition of the advisory bodies, in addition to the data outlined above that reports on applications and appointments over the last year.

50. This year the survey ran online from 19 April to 17 May 2017. An email invitation was sent out to 1090 committee members, of which 12 were returned as undelivered. The overall response rate was 69% with 927 responses received. This is lower than last year (78%) but the same as 2015. This year we asked respondents whether they were a committee member appointed for their lay expertise or were appointed for their professional expertise (referred to as non-lay members in this report). Of the 927 responses:

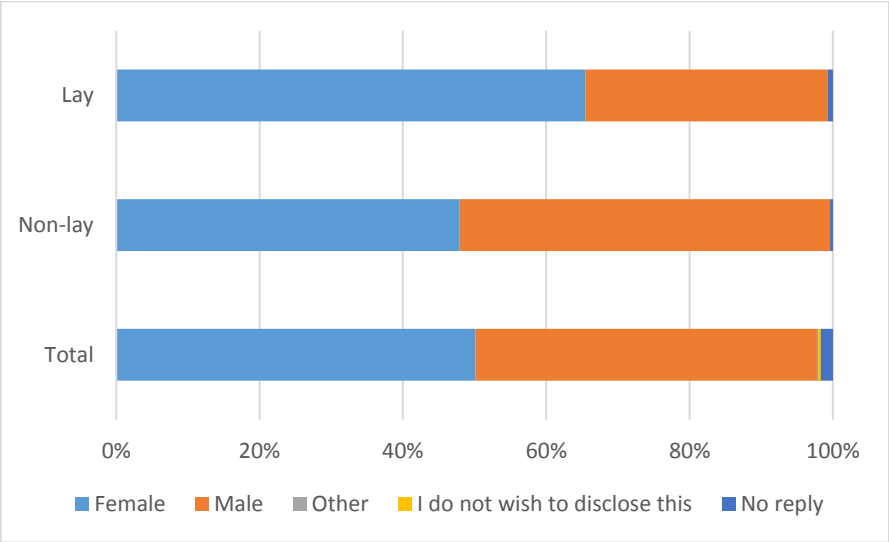
    - 146 (16%) were from lay members
    - 759 (82%) were from non-lay members
    - 22 (2%) did not answer whether they were a lay or non-lay member.[3]

51. The responses are outlined below.

[3] In the charts below the 'total' category includes all 927 respondents, including the 22 respondents who did not identify whether they were a lay or non-lay member

Gender

Chart 1: Gender: advisory committee members



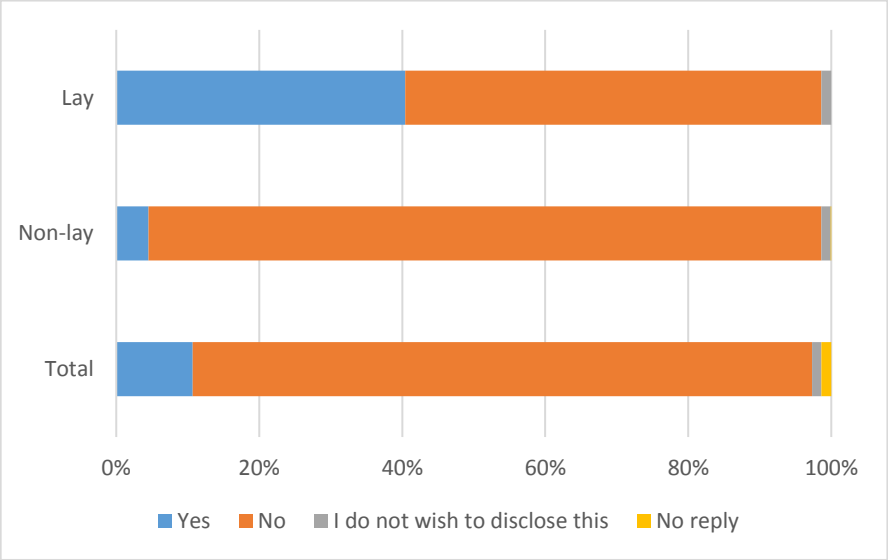
52. In the 2017 survey 50% of respondents were women and 48% were men. In 2016 46% of respondents were women and 43% were men.

53. There is variation in the gender balance across the advisory bodies and between type of member. The proportion of respondents who were women was higher for lay members (65%) than non-lay members (48%). The proportion of respondents who were women was lowest on the Diagnostics Advisory Committee[4] (20%), Interventional Procedures Advisory Committee (21%), and Medical Technologies Advisory Committee (24%). The National Collaborating Centre for Social Care and National Guidelines Alliance guideline committees had the highest proportion of respondents who were women (65% and 63% respectively).

[4] Standing members

Disability

Chart 2: Disability: advisory committee members



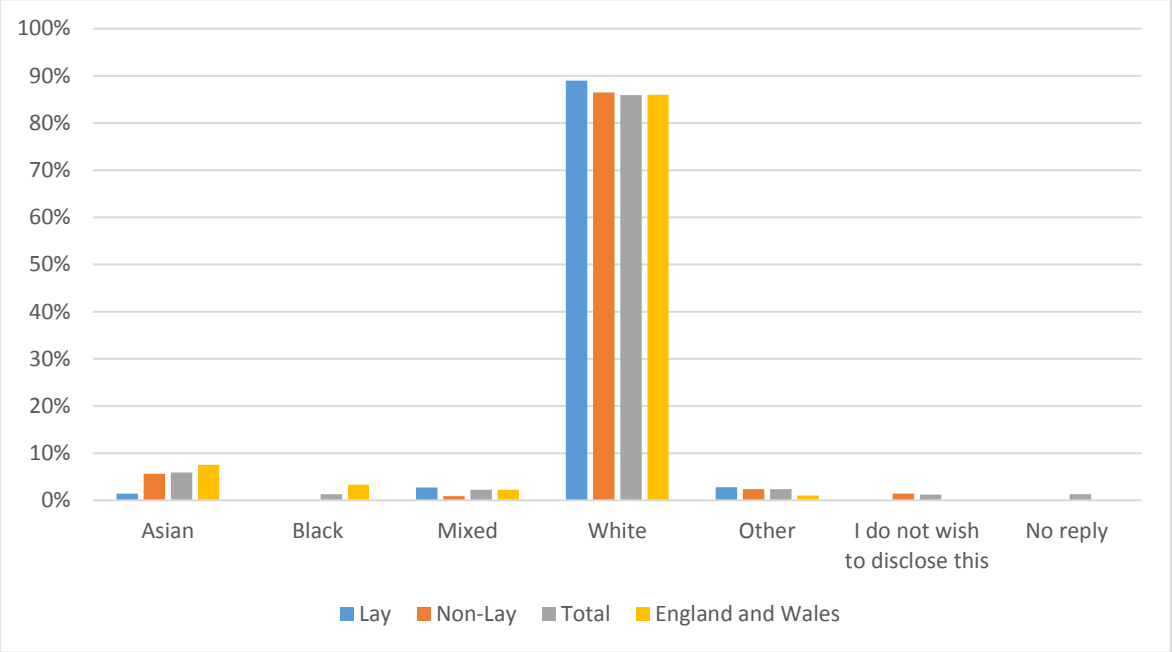
54. In the 2017 survey 11% of respondents identified themselves as disabled, an increase from 8% in 2016 and 6% in 2015. 40% of the lay member respondents identified themselves as disabled.

55. In the 2017 survey 87% respondents did not identify themselves as disabled. In comparison, 82% of the England and Wales population in the 2011 census did not have an activity limiting health problem or disability.

56. The Diagnostics Advisory Committee, Highly Specialised Technologies Evaluation Committee, and the Patient Access Scheme Liaison Unit Expert Panel had no respondents who identified themselves as disabled. The proportion of respondents who identified themselves as disabled was highest on the National Collaborating Centre for Social Care guideline committees (24%), the Medical Technologies Advisory Committee (19%), and Quality Standards Advisory Committee (16%).

Ethnicity

Chart 3: Ethnicity: advisory committee members



57. In the 2017 survey 76% of respondents identified themselves of white British ethnicity. This compares to 78% in 2016 and 77% in 2015.

58. The proportion of respondents who identified themselves of white British ethnicity was higher amongst lay members (82%) than non-lay members (76%).

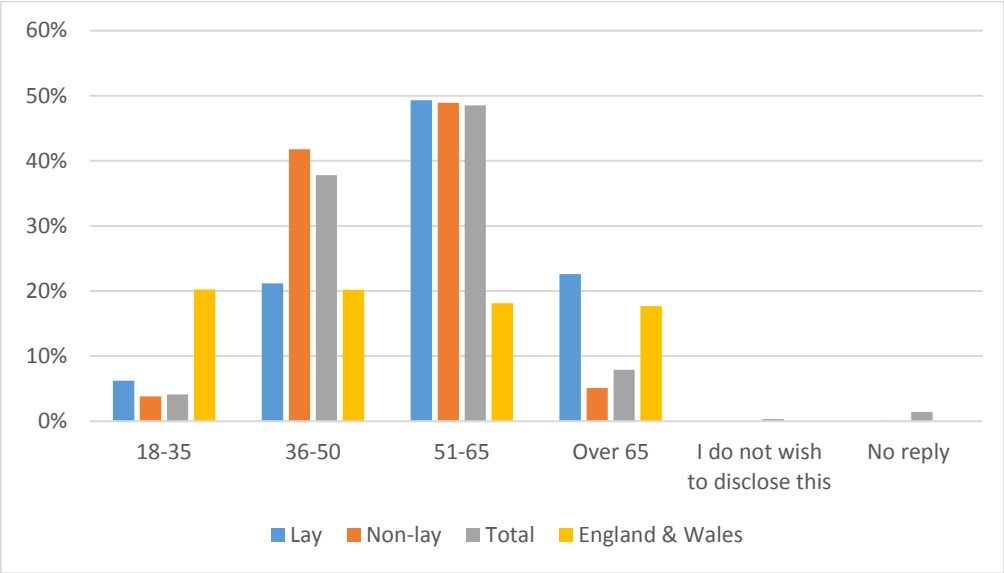
59. As shown in the chart above, the proportion of respondents who identified themselves of white ethnicity[5] and mixed ethnicity is in line with the general population (England and Wales, 2011 census). Compared to the general population there continues to be underrepresentation of people of Asian and black ethnicity, particularly for lay roles.

60. The proportion of respondents who identified themselves of non-white ethnicity was highest on the Highly Specialised Technologies Evaluation Committee (23%) and Medical Technologies Advisory Committee (19%).

[5] White – British, white – Irish, white – any other background

Age

Chart 4: Age distribution: advisory committee members



61. Almost half (49%) of the respondents in the 2017 survey were aged between 51 and 65 years old, and 86% between 36 and 65 years old. Overall, the age profile is similar to that in the 2016 survey.

62. The proportion of respondents between 18 and 35 years old was higher for lay members (6%) than non-lay members (4%), as was the proportion of respondents over 65 (23% of lay members and 5% of non-lay members).

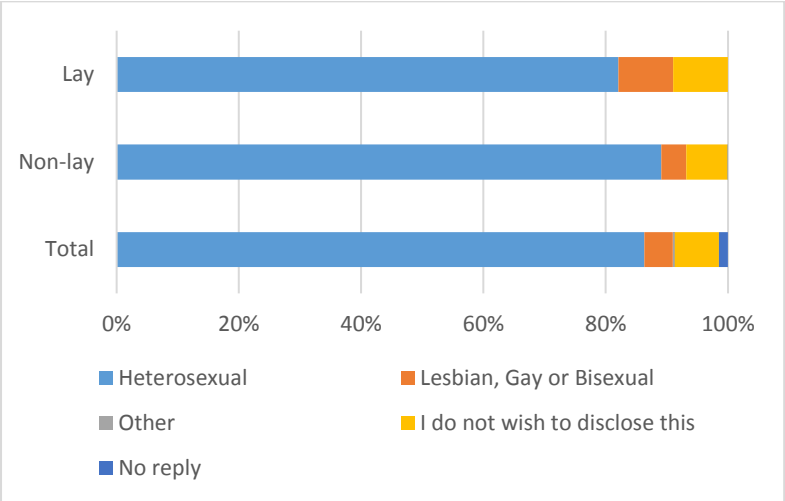
63. Compared to the general population (England and Wales, Office for National Statistics 2014 estimates) committees are under-representative of those under 35 years old and over 65 years old.[6] This is a likely consequence of seeking very experienced and currently practising health and social care professionals for non-lay roles.

64. The proportion of respondents 50 years old or under was lowest on the Indicator Advisory Committee (26%), Interventional Procedures Advisory Committee (32%), and Quality Standards Advisory Committee (32%). It was highest on NICE's internal guideline committees (49%), the Highly Specialised Technologies Evaluation Committee (46%), and National Guidelines Alliance guideline committees (45%).

[6] Due to the format for the availability of data from the Office of National Statistics, the England and Wales data uses the following categories: 20-34 years old, 35-49 years old, 50-64 years old, over 65 years old

Sexual orientation

Chart 5: Sexual orientation: advisory committee members



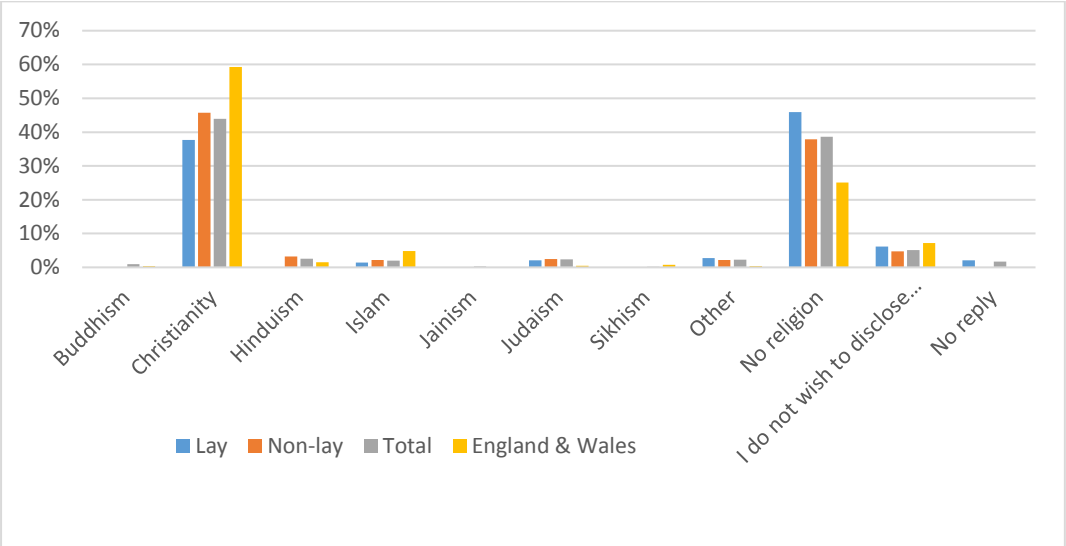
65. In the 2017 survey 86% of respondents stated their sexual orientation to be heterosexual; 5% gay, lesbian or bisexual; 0.3% other; and 9% did not answer or provide this information. In 2016, 88% of NICE respondents stated their sexual orientation as heterosexual; 5% gay, lesbian or bisexual; 0.1% other; and 7% did not answer.

66. The proportion of respondents who stated their sexual orientation as gay, lesbian or bisexual was higher for lay members (9%) than non-lay members (4%).

67. In the 2015 Annual Population Survey published by the Office for National Statistics, 94% of the UK population identified themselves as heterosexual; 2% as gay, lesbian or bisexual; 0.4% other; and 4.1% did not know or answer.

Religion or belief

Chart 6: Religion or belief: advisory committee members



68. As in 2016, the largest proportion of responses to the 2017 survey were from those who identified themselves of Christian belief (44% in 2017 and 47% in 2016) and of no religion (39% in 2017 and 37% in 2016).

69. The proportion of respondents who identified themselves of Christian belief was higher for non-lay members (46%) than lay members (38%). The proportion of respondents who declared they had no religion was higher for lay members (46%) than non-lay members (38%).

70. Compared to the general population (England and Wales, 2011 census) NICE's committees are under-representative of those of Christian and Muslim belief, and over-representative of those without a religion.

71. The proportion of respondents who identified themselves of Christian belief was highest on the Indicator Advisory Committee (68%) and lowest on the Technology Appraisal Committees (30%).

Benchmarking performance

72. NICE is unique in the way it uses advisory bodies and in the number it creates, so it is difficult to find information for purposes of comparison on bodies elsewhere with a similar function. Public bodies are probably the nearest equivalent when it comes to the capabilities required of members, even if they may have less need of the concentration of technical knowledge evident in NICE's advisory bodies.

73. Table 2 overleaf compares the composition of the NICE advisory bodies (using the results of the 2017 Picker survey) with the population of England (using the 2011 census), and statistics published by the Commissioner for Public Appointments (CPA) on regulated appointments made by Ministers between 1 April 2015 and 31 March 2016.[7]

74. The CPA information does not include religion/belief or sexual orientation of members of public bodies, and information on ethnicity is reported in less granularity. It is also important to note the non-disclosure rate for the CPA appointments.

75. The data indicates that:

- The proportion of women on NICE committees is higher than for the CPA appointments in 2015-16 in both the NHS and overall.
- The proportion of members of non-white ethnicity on NICE's committees is double that for the CPA appointments in 2015-16. However, this may in part be due to the non-disclosure rate for the CPA appointments. The CPA appointments to the NHS have a lower non-disclosure rate, and the ethnicity of appointees more closely aligns with the NICE committees.
- The proportion of people identifying themselves as disabled on NICE's committees is higher than for CPA appointments in both the NHS and all public bodies, although this remains lower than the overall population.

Table 2: NICE compared with 'benchmark' organisations

	NICE advisory bodies 2017	All public bodies 2015-16	NHS public bodies 2015-16	England population 2011
	%	%	%	%
Sex				
Men	48	47	63	49
Women	50	39	35	51
Undisclosed / not known	2	14	2	0
Race				
Black, Asian & minority ethnic group (includes mixed)	12	6	10	14

[7] https://publicappointmentscommissioner.independent.gov.uk/10-aug-the-final-ocpa-stats-bulletin-9/

White	86	68	88	85
Undisclosed / not known	3	25	2	0
Disability				
Yes	11	4	6	18
No	87	53	92	82
Undisclosed / not known	3	43	2	0

Equality issues impacting on NICE guidance

76. For the purposes of the public sector equality duty, NICE treats each item of its guidance as an individual policy which requires an equality impact assessment. The aim of this analysis is to ensure that, wherever there is sufficient evidence, NICE's recommendations support local and national efforts to eliminate discrimination, advance equality of opportunity, and foster good relations. We take account of the inputs of organisations and individuals with an interest in equality. Similarly, we take equality issues into account when developing our advice products.

77. In assessing the clinical and cost effectiveness of interventions and the validity of quality standards and indicators, we consider their impacts on:

- people sharing the characteristics protected by the 2010 Equality Act
- population groups experiencing health inequalities arising from socioeconomic factors
- 'other' groups of people whose health may be affected because they have particular circumstances, behaviours or conditions in common.

78. 'Other' groups identified in guidance and quality standards development during the year and resulted in an impact on recommendations include:

- refugees, asylum seekers and recent immigrants
- people with drug misuse problems
- people in prison
- people living in rural / remote areas
- people whose first language is not English
- people with comorbidities.

79. Identification of ‘other’ groups is an aspect of NICE’s compliance with both general public law requirements to act fairly and reasonably and human rights obligations. Article 14 of the European Convention on Human Rights, as affirmed in the Human Rights Act 1998, prohibits discrimination in relation to Convention rights and freedoms that go beyond the Equality Act in that they include grounds of ‘other status’, by which is meant any definable common characteristic.

80. People may share more than one protected characteristic, be affected by socioeconomic factors, and be in an ‘other’ group, so our equality analysis has to accommodate many permutations.

81. Table 3 provides a breakdown by protected and other characteristics of the findings of the equality analyses carried out in 2016-17 on NICE guidance, NICE quality standards, and indicators, and the effects of this analysis on final recommendations. It indicates for example, that during the production of the 5 pieces of diagnostic guidance published in 2016-17, 7 potential equality issues were identified, 1 of which related to age. 2 of the 7 potential issues subsequently impacted on recommendations.

82. The table indicates variation in the number of equality issues identified between guidance programmes. The cross-Institute equality and diversity group will consider whether this reflects the different nature of the guidance programmes and the guidance topics, or there is inconsistency in the equality impact assessment process.

Table 3: Summary of equality analysis of published guidance

Guidance type (number of items of guidance published)	Number of equality issues identified	Breakdown of potential equality issues identified by protected, socioeconomic, and 'other' characteristic										Number with an impact on recommendations
		Age	Disability	Gender reassignment	Pregnancy and maternity	Race	Religion or belief	Sex	Sexual orientation	Socio-economic	Other	
DG (5)	**7**	1	0	2	0	2	1	0	0	0	1	**2**
HST (2)	**3**	0	0	0	0	0	0	0	0	1	2	**0**
IPG (25)	**81**	24	14	0	1	9	2	21	0	4	6	**0**
MTG (5)	**3**	1	1	0	0	1	0	0	0	0	0	**1**
TA (53)	**42**	9	2	2	1	9	1	1	0	0	17	**3**
CG (13)	**24**	5	8	0	0	5	2	0	1	2	1	**19**
PHG (5)	**28**	5	3	3	0	3	0	3	4	4	3	**8**
IAC (10)	**5**	1	2	0	0	1	1	0	0	0	0	**2**
QS (32)	**92**	10	19	3	1	7	7	2	1	8	34	**53**
MMIC (1)	**0**	0	0	0	0	0	0	0	0	0	0	**0**
SC (1)	**19**	2	2	1	0	1	0	0	1	1	11	**15**
CGU (11)	**44**	6	5	0	4	8	1	7	2	1	10	**10**
Total (163)	**348**	**64**	**56**	**11**	**7**	**46**	**15**	**34**	**9**	**21**	**85**	**113**

DG: Diagnostics guidance

IPG: Interventional procedures guidance

MTG: Medical technologies guidance

TA: Technology appraisals

CG: Clinical guidelines

HST: Highly specialised technologies evaluations

PHG: Public health guidelines

IAC: Indicator set

MMIC: Managing medicines in the community guideline

QS: Quality standards

SC: Social care guidelines

CGU: Clinical guideline updates

83. Table 4 summarises equality issues identified and their impact on recommendations by protected and other characteristics, and compares this year with previous years.

Table 4: Impact on recommendations by protected and other characteristic

Protected characteristic	Number & % of equality issues found				Number & % of issues with impact on recommendations			
	2013-14	2014-15	2015-16	2016-17	2013-14	2014-15	2015-16	2016-17
Age	73 (22%)	79 (21%)	87 (19%)	64 (18%)	23 (20%)	32 (18%)	30 (15%)	15 (13%)
Disability	66 (20%)	72 (19%)	85 (19%)	56 (16%)	24 (21%)	30 (17%)	41 (21%)	37 (33%)
Gender reassignment	2 (1%)	5 (1%)	10 (2%)	11 (3%)	0 (0%)	1 (1%)	4 (2%)	3 (3%)
Pregnancy & maternity	9 (3%)	13 (3%)	18 (4%)	7 (2%)	6 (5%)	3 (2%)	2 (1%)	2 (2%)
Race	58 (18%)	58 (15%)	54 (12%)	46 (13%)	18 (16%)	28 (16%)	26 (13%)	10 (9%)
Religion or belief	13 (4%)	22 (6%)	21 (5%)	15 (4%)	7 (6%)	9 (5%)	13 (7%)	8 (7%)
Sex	31 (10%)	28 (7%)	46 (10%)	34 (10%)	6 (5%)	11 (6%)	11 (6%)	3 (3%)
Sexual orientation	5 (2%)	10 (3%)	9 (2%)	9 (3%)	3 (3%)	4 (2%)	4 (2%)	3 (3%)
Socio-economic	22 (7%)	32 (8%)	37 (8%)	21 (6%)	5 (4%)	19 (11%)	18 (9%)	8 (7%)
Other	46 (14%)	66 (17%)	80 (18%)	85 (24%)	21 (19%)	42 (23%)	45 (23%)	24 (21%)
Total number of issues	**325**	**385**	**447**	**348**	**113**	**179**	**194**	**113**
Total guidance produced	**136**	**163**	**191**	**163**				

84. In 2016-17, 348 potential equality issues were identified during the development of the 163 pieces of published guidance. The outcome of advisory bodies' equality analysis was that consideration of 113 (32%) of the issues identified had an impact on recommendations, whereas consideration of 235 (68%) issues did not. The ratio of the number of equality issues identified to the total amount of guidance produced was lower in 2016-17 than in 2015-16 and 2014-15. As was the ratio of the number of issues that impacted on recommendations to total amount of guidance produced.

85. Age, disability and race continue to account for the greatest number of equality issues both in terms of initial identification and those which impacted on recommendations.

86. Examples of how equalities considerations impacted recommendations are outlined below.

NG65: Spondyloarthritis in over 16s: diagnosis and management

87. During both the scoping and development process the underdiagnosis of axial spondyloarthritis in women was identified. To address this, the committee agreed the following recommendation for when healthcare professionals suspect spondyloarthritis:

    'Be aware that axial spondyloarthritis affects a similar number of women as men.'

QS129: Contraception

88. Quality statement 1 states: "Women asking for contraception from contraceptive services are given information about, and offered a choice of, all methods including long-acting reversible contraception."

89. Following comments from stakeholders at consultation, the Quality Standards Advisory Committee wanted to highlight that a woman's age, religion and culture may affect which contraceptive methods are considered suitable and included the following:

    > "Age, religion and culture may affect which contraceptive methods the woman considers suitable. When discussing contraception healthcare practitioners should give information about all methods and allow the woman to choose the method that suits her best."

NM143: Obesity in adults

90. NICE menu indicator NM143 is "the percentage of patients aged 18 or over (on or after 1 April 2017) who have had a record of a BMI being calculated in the preceding 5 years (and after their 18th birthday".

91. It aims to encourage recording of body mass index (BMI) in order to identify overweight or obesity in adults. During development, the Indicator Advisory Committee highlighted that in some ethnic groups, people with a BMI greater than or equal to 23kg/m2 are classified as being overweight as opposed to 25kg/m2 because of an increased risk of conditions such as diabetes at a lower BMI.

92. Part of the piloting process specifically examined recording of ethnicity within general practice clinical systems. This provided assurance that recording of ethnicity was at sufficient levels to ensure that people could be categorised correctly following recording of BMI.

QS145: Vaccine uptake in under 19s

93. Quality statement 2 states: "Children and young people identified as having missed a childhood vaccination are offered the outstanding vaccination."

94. When a child or young person is found to have missed a vaccination, it is important that healthcare professionals discuss the importance of, and any concerns about, the outstanding vaccination with the child or young person and, if appropriate, their parents or carers. This can increase immunisation coverage in the population and provide protection against disease for the child or young person.

95. Following equality impact assessment the Quality Standards Advisory Committee highlighted that:

> "Healthcare professionals need to be aware that some children may arrive in the UK without vaccination records, and vaccination schedules in other countries may be different from the current UK programme".

TA387 Abiraterone for the treatment of metastatic castration-resistant prostate cancer not previously treated with chemotherapy

96. The scope remit and population referred to men with prostate cancer. However, an issue was raised during the scoping workshop regarding people who have undergone gender reassignment.

97. People who have undergone a male-to-female gender reassignment will still have a prostate and can therefore develop cancer of the prostate. The issue raised was that those people may be uncomfortable accessing a male urology clinic. Additionally, using the term 'men' in the remit and population section would not be appropriate for this population.

98. The committee therefore agreed its recommendations in section 1.1 of the guidance should apply to 'people' with prostate cancer.

DG27 Molecular testing strategies for Lynch syndrome in people with colorectal cancer.

99. Prior to the NICE diagnostics guidance, current practice was to offer tumour testing for Lynch syndrome markers to people under 50 years old only. This was based on clinical evidence to suggest that one of the markers, microsatellite instability, may be more common in tumours in older people. This would result in more false positive results in people over 50 years old.

100. The diagnostics guidance included age as subgroups to account for this, but found that the molecular testing strategies were cost-effective in older age groups. The Diagnostics Advisory Committee considered that although the prevalence of Lynch syndrome is much higher in younger people with colorectal cancer, it can still cause colorectal cancer in older people. Despite the lower prevalence of Lynch syndrome in older people, the greater number of colorectal cancer diagnoses in these age groups could mean that the absolute number of

people who could benefit from a Lynch syndrome diagnosis may be similar to that in younger age groups.

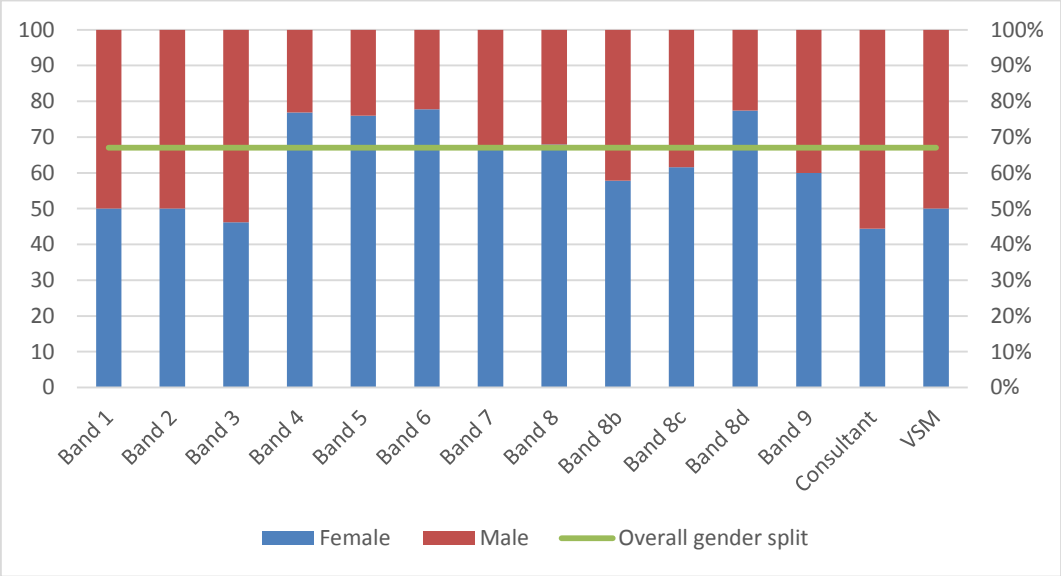
101. The committee therefore recommended that testing should be offered to all people with colorectal cancer, when first diagnosed, using immunohistochemistry (IHC) for mismatch repair proteins or microsatellite instability testing to identify tumours with deficient DNA mismatch repair, and to guide further sequential testing for Lynch syndrome.

Workforce

102. This section provides a summary of the workforce profile by equality category, as at 31 March 2017. Further information is available in the annual workforce report presented to the Board in July 2017.

Gender

Chart 7: Gender mix of staff by grade



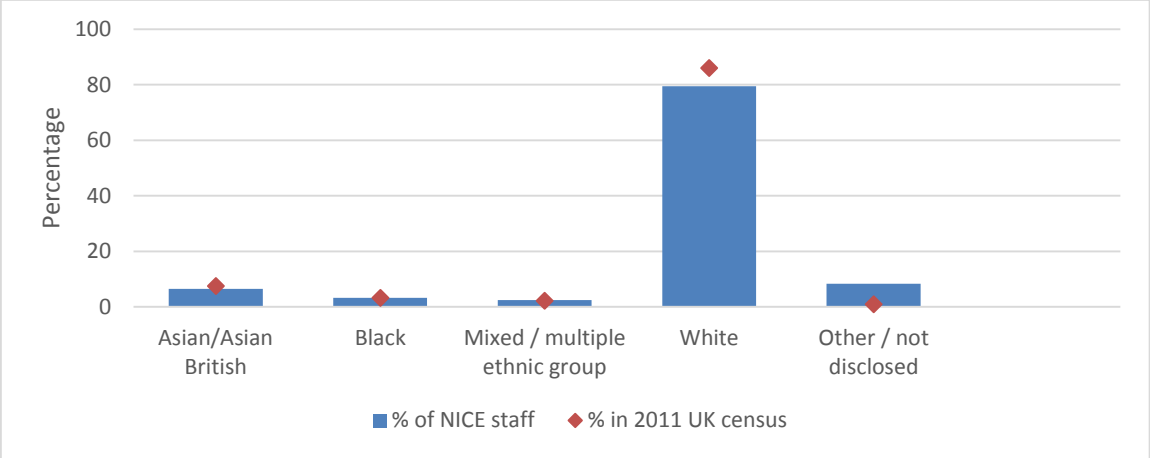
103. Compared to the overall gender split of the workforce, men are slightly overrepresented in the more senior grades and slightly underrepresented in more junior grades. The overall gender split of the workforce has not changed significantly over time.

Disability

104. The range of disabilities that staff are encouraged to declare include learning disability or difficulty, long-standing illness, mental health condition, physical impairment, and sensory impairment. 21 staff (3% of the workforce) have identified themselves as disabled.

Ethnicity

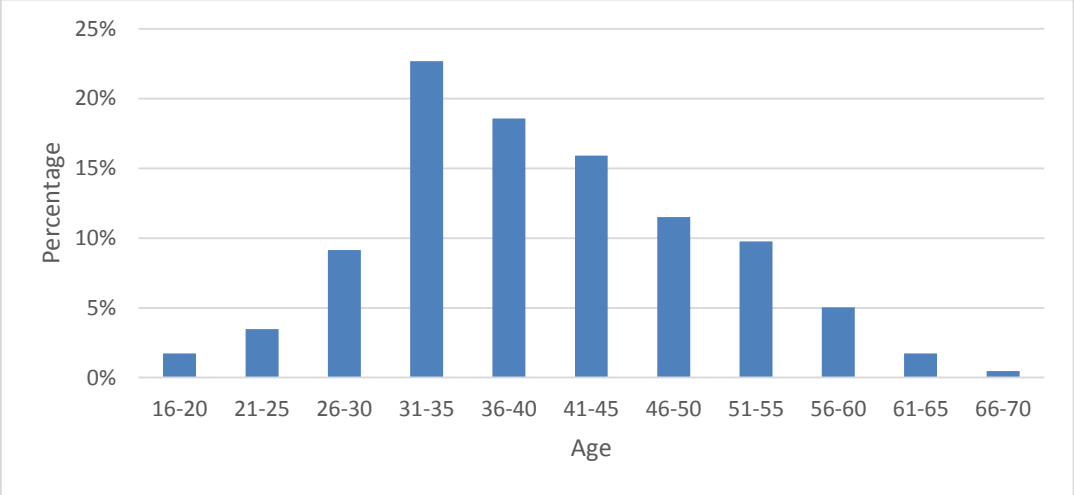
Chart 8: Ethnicity: NICE staff



105. As in 2015-16, the majority of staff (79%) are of white ethnicity. In the 2011 census, the figure for England and Wales overall was 86%.

Age

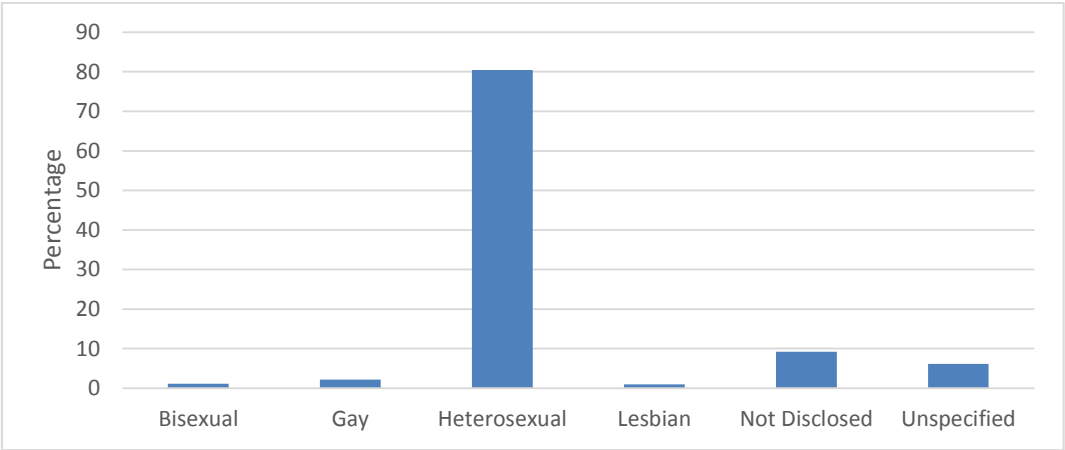
Chart 9: Age profile: NICE staff



106. Just over half (56%) of NICE's workforce are 40 years old or less. Compared to 2015-16 data, there has been a small increase in the 16 to 20 years old category, which is likely attributable to the increased number of apprentices since last year.

Sexual orientation

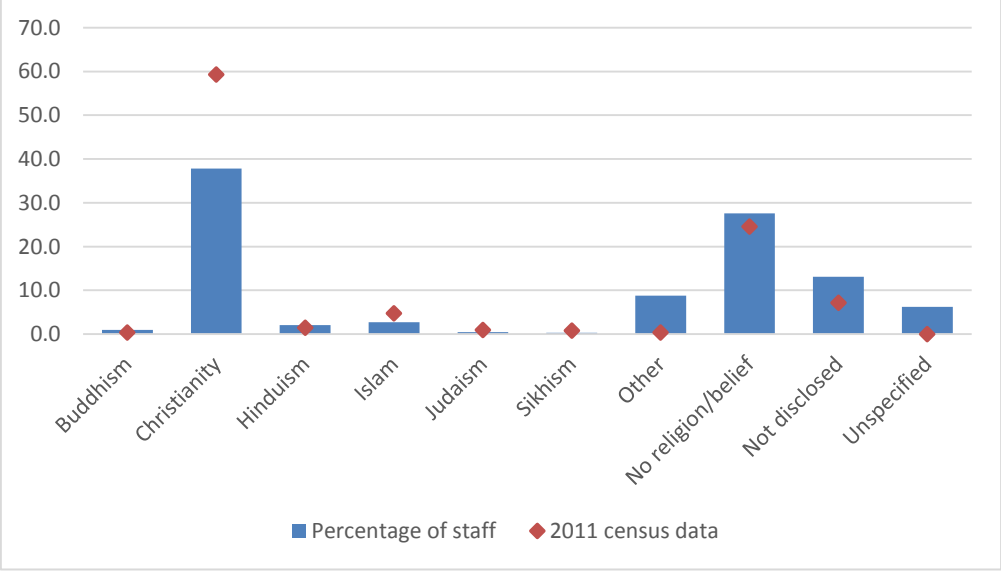
Chart 10: Sexual orientation: NICE staff



107. The profile is little changed from 2015-16, with 4% of staff stating their sexual orientation as gay, lesbian or bisexual. The combined non-disclosure and non-specified rate is 15%.

Religion and belief

Chart 11: Religion and belief: NICE staff



108. Of the staff that disclosed their religion or belief, the largest group is Christianity (38%) and the next highest is no religion (28%), which is similar to 2015-16.

Employment applicants and appointees

109. Data on employment applicants and appointees is gathered via the equality profile of individuals when they complete their application on the NHS jobs recruitment system. This data is then automatically transferred to the Electronic

Staff Record (ESR) system. There were 3,584 applications for the 194 posts advertised in 2016-17.

110. Discrepancies between the profile of applicants and appointees include:

- Gender: Women account for a higher proportion of appointees (74%) than applicants (63%).
- Ethnicity: 54% of applicants identified themselves of white ethnicity, compared to 71% of those appointed.
- Age: Those aged between 35 and 44 years old accounted for 27% of applicants and 40% of appointees. 14% of applicants were under 25 years old, compared to 8% of appointees.

111. Further information is contained in the annual workforce report to the July Board.

National Institute for Health and Care Excellence

August 2017